

Sample Member Special Needs Assessment Form

Member Information

First Name	Last Name	Middle Initial
Street Address	City	State
Home Phone	Cell Phone	Email Address

Do you live alone? ☐ Yes ☐ No

If you live alone and are home-bound is there someone (such as a friend or relative) who checks in on you regularly? ☐ Yes ☐ No

Do you have a chronic medical condition? ☐ Yes ☐ No

Do you take prescription drugs regularly? ☐ Yes ☐ No

Do you need help getting around? ☐ Yes ☐ No

Can you cook for yourself? ☐ Yes ☐ No

Do you have any other special needs? Please specify.

Emergency Contact Information

First Name	Last Name	Middle Initial
Street Address	City	State
Home Phone	Cell Phone	Email Address